

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

|  |                                      |
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| Facility's Name: Oililua Eldercare Inc.              | CHAPTER 100.1                        |
| Address:<br>429 Ulupaina Street Kailua, Hawaii 96734 | Inspection Date: May 21, 2019 Annual |

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

|                                     | <b>RULES (CRITERIA)</b>   | <b>PLAN OF CORRECTION</b>  | <b>Completion<br/>Date</b> |
|-------------------------------------|---|--|----------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(b)<br/>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b><br/>Initial tuberculosis clearances not available for review:</p> <ul style="list-style-type: none"> <li>• SCG#1 – Record of positive skin test and subsequent negative chest x-ray</li> <li>• PCG – Record of positive skin test</li> </ul> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> |                            |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(1)<br/> The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><b><u>FINDINGS</u></b><br/> Resident #1 – Admission assessment incomplete</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU<br/>CORRECTED THE DEFICIENCY</b></p> |                            |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-88 <u>Case management qualifications and services.</u><br/>(c)(2)<br/>Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><b><u>FINDINGS</u></b></p> <ul style="list-style-type: none"> <li>• No RN Case Management interim Care Plan (due within 48 hours of admission) or</li> <li>• No RN Case Management complete care plan (due within 7 days of admission) available for review</li> </ul> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> |                            |

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_